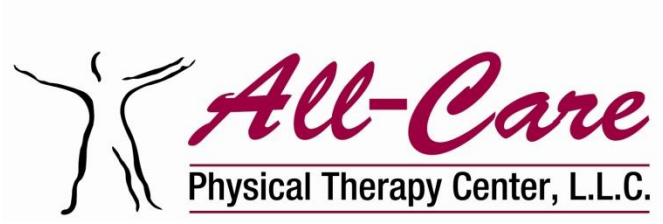

1-(855) 3-ALLCARE

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our billing office. Necessary forms will be completed to file for insurance carrier payments. I realize that I am responsible for my co-pay plus any deductible or amount indicated on my explanation of benefits as patient responsibility. I am aware that there is a $25 fee for all returned checks. If my account is sent to collection, I realize that I am responsible for the collection fees and additional attorney's fees in the amount of 33.3% of the bill.

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment(s) directly to All-Care Physical Therapy Center, LLC rendered to myself and or/my dependents regardless of my insurance benefits, if any.

Authorization to Release Information

I hereby authorize All-Care Physical Therapy Center, LLC to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from All-Care Physical Therapy Center, LLC on behalf of myself and/or my dependants, and understanding that by making this request, I become fully financially responsible for any charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature	Date
Witness	Date

All-Care Physical Therapy Center

Directions: Please fill in all spaces, if not applicable, please put N/A.

General Information

Name:				**Home Phone:**	
Email:		**SSN:**		**Cell Phone:**	
Gender:	**Female Male Other**			**Marital Status:**	
Address:					
Employer:		**Empl. Phone:**		**Birth date:**	
Employer Address:				**Occupation:**	
Attorney:				**Atty. Phone:**	

Guarantor Information if *NOT SELF*

Guarantor Name:		**Phone #:**	
Guarantor Address: (If different from Patient):			

Emergency Contact

Emergency Contact:		**Relationship:**	
Phone:			

Injury Information

Date of Injury	**Work Related?**	**Auto Related**	**Case Manager:**	**Phone Number**
		- State -		
Carrier:			**Claim Number:**	
Policy Holder			**Relationship to the Patient:**	

Payment Services:

- All co-payments are due at time of service. A $25 fee may be charged for any returned checks.
- Please be advised that **Medicare** will ***not*** pay for a home health aide & physical therapy at the same time.

Primary Policy Information

Name of Insurance	**Policy / ID #**	**Group #**	**Name of Insured**	**Insured DOB**	**Effective To**
Comments:					

Secondary Policy Information

Name of Insurance	**Policy / ID #**	**Group #**	**Name of Insured**	**Insured DOB**	**Effective To**
Comments:					

Tertiary Insurance Policy Information

Name of Insurance	**Policy / ID #**	**Group #**	**Name of Insured**	**Insured DOB**	**Effective To**
Comments:					

I have answered all of the above questions accurately to the best of my knowledge. I hereby authorize All-Care Physical Therapy Center to perform upon me the appropriate assessment and treatment related to my condition.

Signature: _____ Date: _____

All-Care Physical Therapy Center

Directions: Please fill in all spaces, if not applicable, please put N/A.

Medical History (Please √ all that apply to you.)

_____ Pacemaker	_____ Pregnancy (C-Section? Y/N)	_____ Stroke (R or L side involved)
_____ Chest Pain (nitro? Y/N)	_____ Osteoporosis/Osteopenia	_____ Allergies to Heat/Cold (circle)
_____ High Blood Pressure	_____ Diabetes	_____ Other Allergies _____
_____ Heart Disease/Palpitation	_____ Cancer: Type: _____	_____ Asthma/Breathing Difficulties
_____ Heart Attack	_____ Kidney Problems	_____ Falls/Loss of Balance
_____ Bypass Surgery (CABG)	_____ Bowel/Bladder Abnormalities	_____ Orthopedic Surgery: Type:_____
_____ Dizziness/Fainting	_____ Liver/Gall Bladder Abnormalities	_____ Total Hip (precautions? Y/N)
_____ Seizures	_____ Skin Abnormalities	_____ Total Knee Metal Plates/screws
_____ Smoking, # of Yrs ___	_____ Hernia	_____ Rotator Cuff Repair Arthroscopic

Height: _____ft. _____ in. **Weight:** _____ lbs

Are you presently taking any medications? _____ if yes, please list. _____

_____

Have you received physical therapy treatment before? Y / N For the same problem? Y / N

Did you get imaging studies? (Circle all that apply) X-rays MRI CT scan Bone Scan Other_____

Dates of Imaging: _____

Is there any additional information in your medical history that we should know? _____

_____

Employment Information

Are you presently working? _____What is your occupation? _____

Length of time with work limitations? _____ Any Worker's Comp Case or Litigation? Y /N

Injury Information

Mechanism of Injury: (please circle all that apply)

Work Related Athletic Motor Vehicle Accident Fall Other (Explain): _____

Date of injury, surgery or onset of symptoms: _____ Have you ever experienced these symptoms before? Y / N

Please specify previous injury & date: _____ Date of Next Doctor Visit: _____

Your Information. Your Rights. Our Responsibilities.

SUMMARY:

Your Rights

You have the right to:

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully.***

- Get a copy of your paper or electronic medical record
- Request corrections to your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated
- Request to be treated privately. We will make reasonable efforts to accommodate you.
- Make choices about family and friends with whom we may discuss your condition

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
- Report suspected abuse, neglect, or domestic violence

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information, in a process consistent with federal notification laws.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Please note: For the privacy of other patients, photography and videography are strictly prohibited on the premises of the All-Care facility.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

OFFICE USE ONLY- INABLITY TO SIGN:
Date:__/__/__ Employee Initials:_____
__Individual refused __Emergency
__Communication Barrier
__Other _____

HIPAA ACKNOWLEDGEMENT & AUTHORIZATION FORM

By signing this form, I further authorize All-Care Physical Therapy Center, L.L.C to disclose my protected health & billing information to the following recipients:

_____

(Name) (Relationship) (Phone Number)

_____

(Name) (Relationship) (Phone Number)

_____

(Name) (Relationship) (Phone Number)

The following person(s) are <u>NOT</u> authorized to receive <u>ANY</u> health information:

Print Name: _____ Relationship:_____

Print Name: _____ Relationship:_____

I have read and understand the terms of this authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize All-Care to use or disclose my PHI in the manner described in the Notice of Privacy Practices.

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____ _____

All-Care Employee Name All-Care Employee Signature Date

Effective Date: September 23, 2013
Contact information for the privacy officer:

Annaleigh Eilbacher
67 Lacey Road, Suite 7
Whiting, NJ 08759
aeilbacher@allcareptc.com
732-849-9600 ext. 24

A full and up-to-date copy of this notice can be found on our website: www.allcareptc.com